A BILL FOR AN ACT

CONCERNING THE COLORADO OPTION PLAN TO BE IMPLEMENTED BY EXECUTIVE AGENCIES IN ORDER TO CREATE MORE AFFORDABLE HEALTH BENEFIT PLANS FOR HEALTH CARE CONSUMERS IN THIS STATE.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Beginning January 1, 2022, the bill requires a health insurance carrier (carrier) that offers an individual health benefit plan in this state to offer a Colorado option plan in the Colorado counties where the carrier
offers the individual health benefit plan. The commissioner of insurance (commissioner) is required to develop and implement a Colorado option plan that must:

- Be offered to Colorado residents who purchase health insurance in the individual market;
- Implement a standardized plan that:
  - Allows consumers to easily compare health benefit plans; and
  - Provides first-dollar, predeductible coverage for certain services;
- Include the essential health benefits package;
- Provide different, specific levels of coverage;
- Include a hospital reimbursement rate formula;
- Require hospital participation;
- Require a minimum medical loss ratio of 85%; and
- Require carriers and pharmacy benefit management firms to pass rebate savings through to consumers and document the savings and pass-through in a form and manner determined by the commissioner.

The Colorado option advisory board (board) is created to advise and make recommendations to the commissioner on all aspects of the Colorado option plan.

The bill authorizes the commissioner to promulgate rules to develop, implement, and operate the Colorado option plan, including:

- Expanding the Colorado option plan to the small group market;
- Establishing a hospital reimbursement rate formula; and
- Requiring carriers to offer the Colorado option plan in specific counties.

If a hospital refuses to participate in the Colorado option plan, the department of public health and environment may issue a warning, impose fines, or suspend, revoke, or impose conditions on the hospital's license.

The commissioner, in consultation with the board, is required to evaluate the Colorado option plan beginning July 1, 2024, and each year thereafter.

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1 Be it enacted by the General Assembly of the State of Colorado:

2 SECTION 1. In Colorado Revised Statutes, 10-16-107, add (3.7)

3 as follows:

(3.7) (a) The commissioner shall deny any rate in the individual, small group, or large group market that reflects a cost shift between the Colorado option plan described in section 10-16-1205 and the plan for which the rates are submitted and may consider the total cost of health care in making this determination.

(b) The commissioner may adopt rules as necessary to implement this subsection (3.7).

SECTION 2. In Colorado Revised Statutes, add part 12 to article 16 of title 10 as follows:

PART 12

COLORADO AFFORDABLE HEALTH CARE OPTION

10-16-1201. Short title. The short title of this part 12 is the "COLORADO AFFORDABLE HEALTH CARE OPTION ACT".

10-16-1202. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) Ensuring that all people have access to affordable health care is a challenge that has vexed public officials and policy experts for decades despite seemingly constant efforts to address the issue;

(b) Although great strides have been made in increasing access to health care coverage through federal legislation, not enough has been accomplished to address the affordability of health insurance in Colorado, particularly in the state's rural areas;

(c) To address the issue, in 2019 the general assembly passed legislation that directed the department of health care
POLICY AND FINANCING AND THE DIVISION TO DESIGN A STATE OPTION FOR
HEALTH CARE COVERAGE THAT WOULD BE MORE AFFORDABLE THAN
CURRENT OPTIONS AVAILABLE IN THE INDIVIDUAL AND SMALL GROUP
MARKETS; AND

(d) In their final report for Colorado’s public option, issued November 15, 2019, the Department of Health Care Policy
and Financing and the Division recommended that Colorado
establish a state option for health care coverage offered by
private health insurers and sold in the individual market, both
on and off the exchange.

(2) The General Assembly therefore declares its intent to
establish an affordable health care option, to be known as the "Colorado option plan", through a partnership among state
government, carriers, and hospitals for the purpose of:

(a) Increasing the availability of affordable health
insurance statewide to any resident seeking coverage in the
individual market;

(b) Increasing consumer choice by having at least two
carriers offering health benefit plans in every county;

(c) Raising the medical loss ratio from eighty percent to
eighty-five percent, not including insurance producers'
commissions, only for individuals who purchase the Colorado
option plan;

(d) Setting hospital reimbursement rates for only those
who purchase the Colorado option plan through a public and
transparent formula that supports independent hospitals,
promotes sustainability, helps to stabilize rural hospitals, and
ADDRESSES COLORADO'S HIGH-PROFIT OUTLIER HOSPITALS; AND

(e) REQUIRING THAT ALL COMPENSATION AND REBATES FROM
PRESCRIPTION DRUG MANUFACTURERS PAID TO CARRIERS OR PHARMACY
BENEFIT MANAGEMENT FIRMS BE PASSED THROUGH AS SAVINGS TO
POLICYHOLDERS.

(3) IN ESTABLISHING THE COLORADO OPTION PLAN, THE GENERAL
ASSEMBLY ALSO DECLARES ITS DESIRE TO HAVE A STRONG AND
INDEPENDENT ADVISORY BOARD THAT WILL MONITOR, ADVISE, AND
OVERRULE DECISIONS MADE IN INSTITUTING AND ADMINISTERING THE
COLORADO OPTION PLAN.

10-16-1203. Definitions. As used in this Part 12, unless the
context otherwise requires:

(1) "BOARD" MEANS THE COLORADO OPTION ADVISORY BOARD
CREATED IN SECTION 10-16-1204.

(2) "COLORADO OPTION PLAN" MEANS THE COLORADO OPTION
PLAN DESCRIBED IN SECTION 10-16-1205.

(3) "CRITICAL ACCESS HOSPITAL" MEANS A HOSPITAL THAT IS
FEDERALLY CERTIFIED OR UNDERGOING FEDERAL CERTIFICATION AS A
CRITICAL ACCESS HOSPITAL PURSUANT TO 42 CFR 485, SUBPART F.

(4) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE
HOSPITALS.

(5) "HOSPITAL" MEANS A HOSPITAL LICENSED OR CERTIFIED
PURSUANT TO SECTION 25-1.5-103 (1)(a); EXCEPT THAT "HOSPITAL" DOES
NOT INCLUDE PSYCHIATRIC HOSPITALS, GENERAL HOSPITALS THAT ARE
CERTIFIED AS LONG-TERM CARE HOSPITALS, AND INPATIENT
REHABILITATION FACILITIES.
"INSURANCE PRODUCER" has the meaning set forth in section 10-2-103 (6).

"MEDICARE" means federal insurance or assistance provided by the "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act", as amended, 42 U.S.C. sec. 1395 et seq.

"MEDICARE REIMBURSEMENT RATES" means the schedule of reimbursement rates for particular health care services provided under Medicare.

"REBATE" means a rebate, discount, market-share allowance, remuneration, compensation, or other payment or price concession provided by a prescription drug manufacturer to a pharmacy benefit management firm or carrier.

"SMALL GROUP MARKET" means the market for small group sickness and accident insurance as the term is defined in section 10-16-102 (63).

"STANDARDIZED PLAN" means a health benefit plan that has a defined benefit design and cost-sharing structure for covered health care services.

10-16-1204. Colorado option advisory board - creation - membership - terms - duties - commissioner rules. (1) (a) (I) There is hereby created the Colorado option advisory board for the purpose of making recommendations to develop, implement, and operate the Colorado option plan in the best interests of all Coloradans. The board consists of nine voting members. The executive director of the exchange or the executive director’s designee shall serve as a voting member of the board. On or
BEFORE JULY 15, 2020:

(A) THE GOVERNOR SHALL APPOINT FOUR VOTING NONLEGISLATIVE MEMBERS TO THE BOARD, TWO OF WHOM ARE REPRESENTATIVES OF CONSUMERS WHO HAVE THE HIGHEST BARRIERS TO ACCESSING HEALTH CARE, ONE OF WHOM HAS EXPERTISE OR EXPERIENCE IN THE PROVISION OF HEALTH CARE TO UNINSURED AND LOW-INCOME POPULATIONS, AND ONE OF WHOM HAS EXPERIENCE OR EXPERTISE IN HEALTH CARE FINANCE.


(II) NO MORE THAN FOUR VOTING MEMBERS OF THE BOARD MAY BE FROM THE HEALTH CARE INDUSTRY, INCLUDING HOSPITALS, CARRIERS, INSURANCE PRODUCERS, AND PROVIDERS. THE MEMBERS MUST PUBLICLY DISCLOSE WHETHER THEY HAVE ANY FINANCIAL INTEREST IN THE IMPLEMENTATION OF THE COLORADO OPTION PLAN.

(III) THE PERSONS MAKING THE APPOINTMENTS TO THE BOARD SHALL COORDINATE APPOINTMENTS TO ENSURE THAT:

(A) THE MAJORITY OF THE MEMBERS DO NOT HAVE A FINANCIAL
INTEREST IN THE HEALTH CARE INDUSTRY;

(B) THE MEMBERS REFLECT THE GEOGRAPHIC, ETHNIC, RACIAL, AND ECONOMIC DIVERSITY OF THE STATE;

(C) THE MEMBERS AS A WHOLE HAVE DEMONSTRATED EXPERIENCE AND EXPERTISE IN MOST AREAS OUTLINED IN SUBSECTION (1)(a)(IV) OF THIS SECTION; AND

(D) AT LEAST THREE VOTING MEMBERS OF THE BOARD ARE FROM RURAL AREAS OF THE STATE.

(IV) THE MEMBERS OF THE BOARD MUST HAVE EXPERIENCE OR EXPERTISE IN MOST OF THE FOLLOWING AREAS, AND EACH INDIVIDUAL APPOINTED TO THE BOARD MUST HAVE DEMONSTRATED EXPERIENCE OR EXPERTISE IN AT LEAST TWO OF THE FOLLOWING AREAS:

(A) INDIVIDUAL HEALTH INSURANCE COVERAGE;

(B) VALUE-BASED PURCHASING AND PLAN DESIGN;

(C) HEALTH CARE CONSUMER NAVIGATION AND ASSISTANCE IN ACCESSING HEALTH CARE;

(D) HEALTH CARE FINANCE;

(E) THE PROVISION OF HEALTH CARE SERVICES IN RURAL AREAS;

(F) THE PROVISION OF HEALTH CARE SERVICES TO UNINSURED AND LOW-INCOME POPULATIONS;

(G) HEALTH CARE ACTUARIAL ANALYSIS;

(H) AS A MEMBER OF AN EMPLOYEE ORGANIZATION THAT REPRESENTS EMPLOYEES IN THE HEALTH CARE INDUSTRY;

(I) HEALTH CARE DELIVERY SYSTEMS;

(J) REPRESENTING CONSUMERS IN THE DEVELOPMENT OF HEALTH CARE POLICY;

(K) HOSPITAL ADMINISTRATION; OR
(L) INSURANCE BROKERAGE.

(V) (A) EXCEPT AS PROVIDED IN SUBSECTION (1)(a)(V)(B) OF THIS SECTION, THE TERMS OF OFFICE OF THE VOTING MEMBERS OF THE BOARD ARE THREE YEARS, AND MEMBERS OF THE BOARD MAY SERVE A MAXIMUM OF TWO CONSECUTIVE THREE-YEAR TERMS.

(B) IN ORDER TO ENSURE STAGGERED TERMS, THE INITIAL TERM OF OFFICE OF TWO OF THE VOTING MEMBERS APPOINTED BY THE GOVERNOR AND THE MEMBERS APPOINTED BY THE MINORITY LEADER OF THE SENATE AND THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES IS TWO YEARS. AFTER SERVING AN INITIAL TWO-YEAR TERM, THESE MEMBERS MAY SERVE UP TO TWO ADDITIONAL, CONSECUTIVE THREE-YEAR TERMS.

(b) (I) THE GOVERNOR SHALL APPOINT A REPRESENTATIVE OF EACH OF THE FOLLOWING TO SERVE AS NONVOTING, EX OFFICIO MEMBERS OF THE BOARD:

(A) THE OFFICE OF THE GOVERNOR;

(B) A STATEWIDE ASSOCIATION OF PROFESSIONAL NURSES;

(C) A STATEWIDE ASSOCIATION REPRESENTING PHYSICIANS;

(D) A STATEWIDE ASSOCIATION OF HOSPITALS; AND

(E) A STATEWIDE ASSOCIATION OF CARRIERS.


(c) MEMBERS OF THE BOARD MAY BE REMOVED BY THEIR RESPECTIVE APPOINTING AUTHORITIES FOR CAUSE, INCLUDING INCOMPETENCY, NEGLECT OF DUTY, OR MALFEASANCE IN OFFICE OR ANY
OTHER CAUSE, AND AS MAY BE DEFINED BY THE BYLAWS OF THE BOARD.

(d) If a vacancy occurs on the board, the appointing authority for the vacated position shall fill the vacancy by appointment for the remainder of the unexpired term. If a member is appointed to fill a vacancy and serves for more than half of the unexpired term, the member is eligible to serve one more term.

(2) The commissioner shall convene the board and provide technical and administrative support to assist the board in carrying out its responsibilities pursuant to this part 12. The board shall elect a chair and vice-chair from among the voting members of the board. The board shall meet at least quarterly, hold public meetings, and allow the opportunity for public testimony. The board shall establish bylaws to guide its operation, including the authority to go into executive session to discuss confidential or proprietary information.

(3) Board members may receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the board.

(4) Board members are subject to part 4 of article 6, article 18, and part 2 of article 72 of title 24.

(5) The board shall advise the commissioner on the development, implementation, and operation of the Colorado option plan, including:

(a) A standardized plan as the Colorado option plan;

(b) How pass-through funds from any federal waivers received pursuant to section 25.5-1-129 (7) should be allocated;
Any federal waiver application required in section 25.5-1-129 (7);

Value-based payments and plan design in the Colorado option plan;

On or before January 1, 2023, the timing and feasibility of offering the Colorado option plan in the small group market;

The evaluation of the Colorado option plan, including data and metrics to aid the commissioner or an independent third-party contractor if the commissioner contracts with a third-party pursuant to section 10-16-1207; and

Opportunities to leverage the Colorado option plan to promote innovation that improves the quality of, access to, and affordability of health care.

The board may override a decision of the commissioner concerning the development, implementation, and operation of the Colorado option plan by an affirmative vote of at least seven of the voting members of the board.

10-16-1205. Colorado option plan - carriers required to offer - required components - rules.

Beginning January 1, 2022, a carrier that offers an individual health benefit plan in Colorado shall offer the Colorado option plan in the individual market in each county where the carrier offers an individual health benefit plan.

The commissioner shall ensure that there are at least two carriers that offer the Colorado option plan in each county in the state. In order to ensure that there are at least two carriers offering the Colorado option plan in each county in the
STATE, THE COMMISSIONER MAY, BY RULE, REQUIRE CARRIERS TO OFFER
THE COLORADO OPTION PLAN IN SPECIFIC COUNTIES. IN DETERMINING
WHETHER CARRIERS ARE REQUIRED TO OFFER THE COLORADO OPTION
PLAN IN A SPECIFIC COUNTY, THE COMMISSIONER SHALL CONSIDER:

(I) EACH CARRIER'S STRUCTURE, THE NUMBER OF COVERED LIVES
THE CARRIER HAS IN ALL LINES OF BUSINESS IN EACH COUNTY, AND THE
CARRIER'S EXISTING SERVICE AREAS; AND

(II) ALTERNATIVE HEALTH CARE COVERAGE AVAILABLE IN EACH
COUNTY, INCLUDING HEALTH CARE COVERAGE COOPERATIVES AS DEFINED
IN SECTION 10-16-1002 (2).

(c) THE COMMISSIONS PAID TO INSURANCE PRODUCERS FOR THE
SALE OF THE COLORADO OPTION PLAN MUST BE COMPARABLE TO THE
AVERAGE COMMISSIONS PAID FOR THE SALE OF OTHER PLANS OFFERED IN
THE INDIVIDUAL MARKET.

(2) (a) THE COMMISSIONER SHALL ADOPT RULES TO DEVELOP,
IMPLEMENT, AND OPERATE THE COLORADO OPTION PLAN IN ACCORDANCE
WITH THIS SECTION. IN DEVELOPING THE COLORADO OPTION PLAN, THE
COMMISSIONER SHALL CONSIDER RECOMMENDATIONS FROM THE BOARD.

THE COLORADO OPTION PLAN MUST:

(I) BE OFFERED TO COLORADO RESIDENTS WHO PURCHASE HEALTH
INSURANCE IN THE INDIVIDUAL MARKET, INCLUDING THROUGH THE
EXCHANGE;

(II) IMPLEMENT A STANDARDIZED PLAN THAT:

(A) ALLOWS CONSUMERS TO EASILY COMPARE THE COLORADO
OPTION PLAN WITH OTHER HEALTH BENEFIT PLANS OFFERED IN THE
INDIVIDUAL MARKET; AND

(B) PROVIDES FIRST-DOLLAR, PREDEDUCTIBLE COVERAGE FOR
CERTAIN SERVICES SUCH AS PRIMARY HEALTH CARE AND BEHAVIORAL
HEALTH CARE, AS APPROPRIATE;

(III) INCLUDE THE ESSENTIAL HEALTH BENEFITS PACKAGE;

(IV) PROVIDE AT LEAST BRONZE AND SILVER LEVELS OF COVERAGE
AS DESCRIBED IN SECTION 1302 (d) OF THE FEDERAL ACT AND AS SPECIFIED
IN SECTION 10-16-103.4;

(V) REIMBURSE HOSPITALS FOR INPATIENT AND OUTPATIENT
SERVICES BASED ON THE FORMULA ESTABLISHED PURSUANT TO SECTION
10-16-1206;

(VI) REQUIRE THAT A MINIMUM OF EIGHTY-FIVE PERCENT OF THE
MONEY COLLECTED AS PREMIUMS BE SPENT ON PATIENT CARE, NOT
INCLUDING INSURANCE PRODUCERS' COMMISSIONS; AND

(VII) REQUIRE EACH CARRIER TO REDUCE COLORADO OPTION PLAN
PREMIUMS BY AN AMOUNT EQUAL TO ONE HUNDRED PERCENT OF THE
ESTIMATED REBATES THAT THE CARRIER OR A PHARMACY BENEFIT
MANAGEMENT FIRM ADMINISTERING OR MANAGING PRESCRIPTION DRUG
BENEFITS FOR THE CARRIER RECEIVED FOR PRESCRIPTION DRUGS COVERED
BY THE COLORADO OPTION PLAN IN THE PREVIOUS PLAN YEAR. THE
COMMISSIONER SHALL SPECIFY, BY RULE, THE FORM AND MANNER OF THE
PREMIUM REDUCTION.

(b) IN DEVELOPING THE COLORADO OPTION PLAN, THE
COMMISSIONER SHALL, IN CONSULTATION WITH THE BOARD, THE
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, AND THE
DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, CONSIDER:

(I) LOWERING COSTS TO CONSUMERS, INCLUDING PREMIUM,
COINSURANCE, COPAYMENT, AND DEDUCTIBLE AMOUNTS;

(II) INCREASING ACCESS TO HEALTH CARE;
(III) INCREASING CONSUMER CHOICE;
(IV) REDUCING HEALTH DISPARITIES;
(V) MINIMIZING COST SHIFTING, IMPACTS ON OTHER MARKETS, AND IMPACTS ON THE SUBSIDIZED POPULATION;
(VI) IMPROVING CARE COORDINATION; AND
(VII) INCORPORATING VALUE-BASED PURCHASING AND PLAN DESIGN TO DRIVE MARKETPLACE EFFICIENCIES.

(3) THE COMMISSIONER SHALL ADOPT RULES:
(a) TO MITIGATE ANY ADVERSE IMPACTS THE COLORADO OPTION PLAN HAS ON THE PURCHASING POWER OF EXCHANGE CONSUMERS WHOSE INCOME IS UP TO FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LINE;
(b) CONCERNING THE PREMIUM AMOUNTS FOR SILVER PLANS BASED ON THE ACTUARIAL VALUE OF SILVER PLANS; AND
(c) IMPLEMENTING RECOMMENDATIONS THAT ARE WITHIN THE COMMISSIONER'S AUTHORITY AS A RESULT OF ANY STUDY CONDUCTED PURSUANT TO SECTION 10-16-1104 (2).

10-16-1206. Hospital reimbursement rates - plan expansion - rules. (1) (a) THE COMMISSIONER SHALL, BY RULE, IMPLEMENT A FORMULA THAT SETS REASONABLE CARRIER REIMBURSEMENT RATES TO HOSPITALS FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES UNDER THE COLORADO OPTION PLAN. THE FORMULA MUST BE STRUCTURED TO HELP LOWER PREMIUMS AND OUT-OF-POCKET COSTS FOR CONSUMERS AND TO INCREASE ACCESS TO HEALTH CARE IN RURAL AREAS.

(b) FOR THE 2022 PLAN YEAR AND EACH SUBSEQUENT PLAN YEAR, THE HOSPITAL REIMBURSEMENT RATE FORMULA MUST BE BASED ON A PERCENTAGE OF THE MEDICARE REIMBURSEMENT RATES OR EQUIVALENT RATES FOR THE PLAN YEAR IN WHICH THE FORMULA IS IMPLEMENTED.
(c) Notwithstanding subsection (1)(a) of this section, for the 2022 and 2023 plan years, the base reimbursement rate for hospitals is one hundred fifty-five percent of the hospital's Medicare reimbursement rate or equivalent rate. The base reimbursement rate for a hospital shall be adjusted as follows:

(I) A hospital that is a critical access hospital or that is independent and not part of a health system must receive a twenty-percentage-point increase in the base reimbursement rate. A hospital that is a critical access hospital and is not part of a health system must receive a forty-percentage-point increase in the base reimbursement rate.

(II) A hospital with a combined percentage of Medicare and Medicaid patients that exceeds the statewide average must receive up to a thirty-percentage-point increase in its base reimbursement rate, with the actual increase to be determined based on the hospital's percentage share of Medicaid and Medicare patients.

(III) A hospital that is efficient in managing the underlying cost of care, taking into account the hospital's total margins, operating costs, and net patient revenue, must receive up to a forty-percentage-point increase in its base reimbursement rate.

(2) For the 2024 plan year and each subsequent plan year, the board shall advise the commissioner on adjustments to the formula described in subsection (1)(b) of this section and the percentage adjustments to the base reimbursement rate specified in subsection (1)(c) of this section and other factors to
CONSIDER IN THE HOSPITAL REIMBURSEMENT RATE FORMULA.

(3) THE HOSPITAL REIMBURSEMENT RATE FORMULA DEVELOPED PURSUANT TO SUBSECTION (1) OF THIS SECTION APPLIES TO HOSPITAL SERVICES PROVIDED ON OR AFTER JANUARY 1, 2022, TO COVERED PERSONS ENROLLED IN THE COLORADO OPTION PLAN ON OR AFTER THAT DATE.

(4) WHEN IMPLEMENTING THE HOSPITAL REIMBURSEMENT RATE FORMULA PURSUANT TO THIS SECTION, THE COMMISSIONER SHALL, IN COLLABORATION WITH THE BOARD, CONSULT WITH EMPLOYEE MEMBERSHIP ORGANIZATIONS REPRESENTING HEALTH SYSTEMS' EMPLOYEES IN COLORADO AND WITH HOSPITAL-BASED HEALTH CARE PROVIDERS IN COLORADO AND, BASED ON THE CONSULTATIONS, MAY MAKE CHANGES TO THE HOSPITAL REIMBURSEMENT RATE FORMULA AS APPROPRIATE SO THAT REIMBURSEMENT RATES REFLECT THE COST OF ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR THESE EMPLOYEES TO PROVIDE QUALITY CARE.

(5) (a) THE COMMISSIONER MAY, UPON A DEMONSTRATION BY A HOSPITAL THAT THE HOSPITAL REIMBURSEMENT RATE FOR THAT HOSPITAL WILL HAVE A SIGNIFICANT ADVERSE EFFECT ON ITS FINANCIAL SUSTAINABILITY AND IN CONSULTATION WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE BOARD, EXEMPT A HOSPITAL FROM OR CHANGE THE HOSPITAL REIMBURSEMENT RATE FORMULA DEVELOPED PURSUANT TO THIS SECTION FOR THE HOSPITAL.

(b) IF A HOSPITAL IS NOT EXEMPTED FROM PARTICIPATION IN THE COLORADO OPTION PLAN OR THE REIMBURSEMENT RATE FORMULA AND REFUSES TO PARTICIPATE IN THE COLORADO OPTION PLAN, THE COMMISSIONER SHALL, AFTER CONSULTATION WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE BOARD, NOTIFY THE
DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT OF THE HOSPITAL’S REFUSAL TO PARTICIPATE.

(6) ON OR AFTER JANUARY 1, 2023, WITH THE AFFIRMATIVE VOTE OF THE MAJORITY OF THE VOTING MEMBERS OF THE BOARD, AND IN CONSULTATION WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, THE COMMISSIONER MAY PROMULGATE RULES TO EXPAND THE COLORADO OPTION PLAN TO THE SMALL GROUP MARKET WITH ANY CHANGES TO THE COLORADO OPTION PLAN THAT THE COMMISSIONER DEEMS NECESSARY. A COLORADO OPTION PLAN OFFERED IN THE SMALL GROUP MARKET MUST MEET ALL THE CRITERIA REQUIRED BY SECTION 10-16-1205 FOR THE COLORADO OPTION PLAN OFFERED IN THE INDIVIDUAL MARKET. IN EVALUATING THE EXPANSION OF THE COLORADO OPTION PLAN TO THE SMALL GROUP MARKET, THE COMMISSIONER SHALL CONSIDER WHETHER PARTICIPATION IN A HEALTH CARE COVERAGE COOPERATIVE, AS DEFINED IN SECTION 10-16-1002 (2), WOULD MEET THE REQUIREMENTS TO OFFER THE COLORADO OPTION PLAN IN THE SMALL GROUP MARKET.

COMMITTEE OF REFERENCE AT A HEARING HELD PURSUANT TO SECTION 2-7-203 (2)(a) OF THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT". THE COMMISSIONER MAY CONTRACT WITH AN INDEPENDENT THIRD-PARTY ENTITY TO CONDUCT THE EVALUATION OF THE COLORADO OPTION PLAN. THE REPORT SHALL INCLUDE AN EVALUATION OF:

(a) THE EFFECT OF THE COLORADO OPTION PLAN ON THE INDIVIDUAL MARKET AND ANY COST SHIFTING AMONG MARKETS;

(b) THE EFFECT OF THE COLORADO OPTION PLAN FOR INDIVIDUALS WHO QUALIFY FOR PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS AUTHORIZED UNDER THE FEDERAL ACT;

(c) THE ADEQUACY OF THE NETWORK PROVIDERS IN THE COLORADO OPTION PLAN; AND

(d) OTHER ASPECTS OF THE COLORADO OPTION PLAN AS DETERMINED BY THE COMMISSIONER.

TO THE COMMITTEE OF REFERENCE AT A HEARING HELD PURSUANT TO
SECTION 2-7-203 (2)(a) OF THE "STATE MEASUREMENT FOR
ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART)
GOVERNMENT ACT".

SECTION 3. In Colorado Revised Statutes, **add** 25-3-124 as
follows:

**25-3-124. Hospitals - Colorado option plan - hospital
reimbursement rate formula.** (1) A hospital licensed or certified
by the department pursuant to section 25-1.5-103 (1)(a), other
than a psychiatric hospital, a general hospital that is certified
as a long-term care hospital pursuant to 42 CFR 412.23 (e), or an
inpatient rehabilitation facility, shall participate in the
Colorado option plan described in part 12 of article 16 of title
10, including the hospital reimbursement rate formula
developed pursuant to section 10-16-1206.

(2) (a) If the department receives notice from the
commissioner of insurance pursuant to section 10-16-1206 (5)(b)
that a hospital refuses to participate in the Colorado option
plan as required by subsection (1) of this section, the department
shall issue a warning to the hospital. If the hospital refuses to
participate in the Colorado option plan after receipt of the
warning, the department:

(I) Shall fine the hospital up to ten thousand dollars per
day for the first thirty days that the hospital refuses to
participate and up to forty thousand dollars per day for each
day over thirty days that the hospital refuses to participate; AND
(II) MAY SUSPEND, REVOKE, OR IMPOSE CONDITIONS ON THE
HOSPITAL'S LICENSE.

(b) IN DETERMINING THE APPROPRIATE PENALTY, THE
DEPARTMENT SHALL CONSIDER ANY PENALTIES RECOMMENDED BY THE
COMMISSIONER OF INSURANCE, THE HOSPITAL'S FINANCIAL
CIRCUMSTANCES, AND OTHER CIRCUMSTANCES DEEMED RELEVANT BY THE
DEPARTMENT.

SECTION 4. In Colorado Revised Statutes, 25.5-1-129, add
(7)(a)(III) as follows:

25.5-1-129. State department proposal - state option for health
care coverage - report to general assembly - waiver authorization -
legislative declaration. (7) (a) (III) IN ANY WAIVER OR AMENDMENT TO
THE STATE PLAN UNDER THIS SUBSECTION (7), THE STATE DEPARTMENT
AND THE DIVISION SHALL RECOMMEND THAT AT LEAST EIGHTY PERCENT
OF PASS-THROUGH FUNDING RECEIVED AS A RESULT OF THE COLORADO
OPTION PLAN DESCRIBED IN PART 12 OF ARTICLE 16 OF TITLE 10 BE
DEDICATED TO INCREASING AFFORDABILITY FOR INDIVIDUALS AND
FAMILIES WITH INCOMES UP TO FOUR HUNDRED PERCENT OF THE FEDERAL
POVERTY LINE.

SECTION 5. Safety clause. The general assembly hereby finds,
determines, and declares that this act is necessary for the immediate
preservation of the public peace, health, or safety.